STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY
GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
SACRAMENTO, CA 95814

March 29, 1985

To: All County Welfare Directors
All County Administrative Officers

Letter No. 85- 21

DISABILITY EVALUATIONS -- MEDI-CAL ELIGIBILITY WORKER OBSERVATIONS

The Disability Evaluation Division (DED) of the Department of Social Services recently sent us a copy of a form included by a county in the county's disability evaluation packages. The form is used by the eligibility workers (EWs) to record their observations of the Medi-Cal applicant's condition and attitude when the applicant states that he/she is disabled.

DED has indicated that this form is very helpful to them during the disability evaluation process and would like this form to be incorporated into the application process in all counties. DED has stated that this information would assist their analysts in identifying possible impairments and in evaluating the impact of the impairments on the applicant's ability to function.

Therefore, we have attached a copy of this form for your review and comment. The proposed form is designed to give DED maximum information with minimal use of EW time. After the face-to-face interview the EW would circle the appropriate response on the form and if necessary, make notations under the remarks section. The form would then be submitted to DED along with the disability evaluation package.

In order to evaluate the feasibility of implementing this form we ask that you complete the attached questionnaire. Your participation in this survey will be very helpful to us in determining whether this procedure should be implemented. Please complete and return the attached questionnaire by April 30, 1985.

Please direct any questions regarding this survey to Toni Bailey (916) 324-4953.

Sincerely,

Original signed by

Doris Z. Soderberg, Chief
Medi-Cal Eligibility Branch

Attachment

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants

Expiration Date: May 30, 1985

Return to: Toni Bailey
Policy Analyst
714 P Street, Room 1692
Sacramento, CA 95814
(916) 324-4953

County _____
Contact Person _____
Phone Number _____
Date Completed _____

QUESTIONNAIRE

1. Do you think workers understand and complete this form properly?

   yes _____ no _____

2. Are there any items you would like added or deleted from this form?

   yes _____ no _____

   Explain:

3. What impact will this form have, if any, on eligibility worker workloads?

4. What else should we consider in evaluating this proposal?

5. Do you support this proposal?

Comments (continue on back if necessary):

WORKER OBSERVATIONS

Applicant _____ SSN _____

Circle appropriate responses and explain in remarks where necessary.

1. MC 223 Prepared By: Applicant EW Other _____

2. Command of English: Good Poor None - Speaks _____

3. Literate: Yes Marginal No

4. Behavior: Normal Nervous Depressed Aggressive Hostile

5. Hearing Problem: None Slight Moderate Severe Deaf
(Wearing aid: Yes No)

6. Eyesight: Good Impaired Blind
(Wearing glasses/contacts: Yes No)

7. Appeared: The same as Less than Greater than Stated age

8. Walked: Normally With Limp Other _____

9. Other observable problems: None Unusual Appearance Other Unusual Behavior

Physical Difficulties Mental Difficulties Trembling

Swellings/Deformities Lesions Breathing Difficulties

Walking Aids Pregnant Other

(Explain below if other than "None")

Remarks: _____

_____

_____

_____

EW _____ Date _____